

Patient Name _____

Diagnosis _____

Conditions

- | | | |
|---|---|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Abnormal Posture | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Abnormal Gait | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Hyperglycemia |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Edema | <input type="checkbox"/> Impaired Fasting Glucose |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Muscle Wasting | <input type="checkbox"/> Dysmetabolic Syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Insulin Resistant | <input type="checkbox"/> Weight Gain |

Frequency:

1 2 3 4 5

times per
week

Duration

4 5 6 7 9

weeks

Procedures

- [] PT Evaluate & Treat
[] MetabolicRx
[] Registered Dietician

Comments

Precautions

Restrictions

Please Send Copies of Test Results and Recent Blood Work

Physician Signature

Date